STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-132
April 22, 2024

TO: All Health Insurers and Health Care Centers Authorized to Conduct Business In Connecticut

RE: Legitimate Disputes Pertaining to Accident and Health Claims – Connecticut Unfair Insurance Practices

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This Bulletin rescinds and replaces Bulletin HC-131 dated February 1, 2024.

This Bulletin identifies issues that the Insurance Commissioner ("Commissioner") has deemed to be legitimate disputes for which an insurer or other claim paying entity may delay payment while working to resolve the dispute in good faith.

A. Timely Claim Payment Requirements and Exception for "Legitimate Disputes"

The Connecticut Unfair Insurance Practices Act ("CUIPA") (see Conn. Gen. Stat. §38a-815 *et seq.*), requires that an insurer or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy pay accident and health claims not later than:

- For claims filed in paper format, sixty days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, and
- For claims filed in electronic format, twenty days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures.

Conn. Gen. Stat. §38a-816(15)(B)(i) and (ii).

These requirements apply except when:

- there is a deficiency in the information needed for processing a claim as determined in accordance with section 38a-477,[1] or

[1] Conn. Gen. Stat.§38a-816(15)(B)(i) and (ii) provide that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall (I) send written notice to or otherwise notify the claimant or health care provider of all alleged deficiencies in information needed for processing the claim not later than *thirty days* for a paper submission and *ten days* for an electronic submission after the insurer receives the claim, and (II) pay the claim not later than *thirty days* for a paper submission and *ten days* for an electronic submission after the insurer receives the information requested.

- the Commissioner determines that a ***legitimate dispute*** exists as to coverage, liability or damages, or that the claimant has fraudulently caused or contributed to the loss.[2]

Conn. Gen. Stat. §38a-477 defines what information is necessary for filing a health claim that is not considered deficient. Health insurers and other claim paying entities are reminded that if claims are submitted with the necessary information required by Conn. Gen. Stat. §38a-477, the claim is considered under Connecticut law to be a complete claim ripe for processing unless the Insurance Commissioner has determined that a ***legitimate dispute*** exists.

B. Legitimate Disputes

The Commissioner has determined that the questions and issues below are legitimate disputes for which an insurer or other claim paying entity may delay payment for a reasonable period while trying to resolve the dispute. Also identified are appropriate investigational parameters for the legitimate disputes.

1. **Whether a claim or condition is preexisting.** Any investigation undertaken to determine if a claim or condition, which is the subject of a new claim, is preexisting should be consistent with the terms of Insurance Department Bulletin HC-66, dated September 24, 2007. Investigations should be limited to issues having a direct relationship to the alleged preexisting claim or condition, which is the subject of the new claim. Any investigation done that is not consistent with the terms of HC-66 may be deemed post-claim underwriting.

2. **Whether the services rendered are medically necessary.** Any investigation to determine if the services rendered are medically necessary must consider the definition of "medically necessary" as established by Conn. Gen. Stat. §38a-482a and §38a-513c.

3. **Whether the services are consistent with emergency medical treatment.** Pursuant to Conn. Gen. Stat. §38a-478r(c), an emergency medical condition is

[2] Pursuant to Conn. Gen. Stat.§38a-816 the following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:…

(15)(A) Failure by an insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, to pay accident and health claims, including, but not limited to, claims for payment or reimbursement to health care providers, within the time periods set forth in subparagraph (B) of this subdivision, *unless the Insurance Commissioner determines that a legitimate dispute exists as to coverage, liability or damages or that the claimant has fraudulently caused or contributed to the loss*. Any insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, who fails to pay such a claim or request within the time periods set forth in subparagraph (B) of this subdivision shall pay the claimant or health care provider the amount of such claim plus interest at the rate of fifteen per cent per annum, in addition to any other penalties which may be imposed pursuant to sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819, inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due a claimant or health care provider pursuant to this section is less than one dollar, the insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center.

a condition such that a prudent layperson, acting reasonably, would have believed that emergency medical treatment is needed.

Each provider is required to code for the presenting symptoms of all emergency claims and each hospital shall record such code for such claims on locator 76 on the UB92 form or its successor. The presenting symptoms, as coded by the provider and recorded by the hospital on the UB92 form or its successor, or the final diagnosis, whichever reasonably indicates an emergency medical condition, shall be the basis for reimbursement or coverage.

Insurers or health care centers may only investigate if the UB92 claim form is not completed as required above. If the information is presented on the claim form as identified above, this would be considered a claim that is complete pursuant to Conn. Gen. Stat. §§38a-477 and 38a-816(15)(B), and must be processed without further investigation.

4. **Potential for Dual Coverage.** Coordination of benefit ("COB") information should be investigated upon presentment of the initial claim for payment where there is an indication of dual coverage. COB should not be investigated for subsequent claims more frequently than once yearly unless there is an indication of changed circumstances.

   COB investigations are acceptable under the following conditions:

   - to determine payment priority if dual coverage is indicated, or
   - if another insurer has been determined to be the primary payor, the secondary carrier may withhold payment until obtaining notification of the primary payment needed to determine secondary liability. The secondary carrier is, however, required to notify the claimant that payment will be withheld until proof of the primary payor's determination has been submitted.

   All COB determinations for group contracts must be consistent with Conn. Agencies Regs. §§ 38a-480-1 through 38a-480-7.

5. **Dependent Eligibility Issues.** These issues refer to verification of dependent status for other than routine information, which should be contained in the insured's enrollment information. Eligibility investigations are acceptable under the following conditions:

   - to verify whether a child or stepchild continues to qualify for coverage as provided by Conn. Gen. Stat. §§38a-497 and 38a-512b;
   - if there is indication of a variance from information on file, information may be sought to verify marital status;

- for mentally or physically handicapped dependents, pursuant to Conn. Gen. Stat. §§38a-489 and 38a-515 proof of the incapacity and dependency shall be furnished to the insurer or health care center by the policyholder or subscriber within thirty-one days of the child's attainment of the limiting age. The insurer or health care center may at any time require proof of the child's continuing incapacity and dependency. After a period of two years has elapsed following the child's attainment of the limiting age the insurer or health care center may require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year.

6. **Lack of Information Pertaining to an Accident.** Claims for health care services rendered in response to accidental injuries may be investigated if the information regarding the nature of the accident and how the injuries were sustained is not provided or is not complete. Investigations should be limited to issues having a direct relationship to the accident.

7. **Suspected Fraudulent Claims.** Claim submissions that provide a reasonable basis for the carrier to suspect fraudulent activity on the part of either the enrollee, member, subscriber or service provider may be investigated. Carriers should be prepared to provide the Commissioner with evidence supporting the basis for any suspected fraud.

8. **Services by Foreign Providers – Extraordinary Circumstances.** Claims submitted that contain bills for reimbursement that are in a foreign language or request payment using a foreign currency may be reasonably delayed in extraordinary circumstance for purposes of obtaining currency conversion rates for the date(s) of service or for translation of the bills into English. Absent extraordinary circumstance, claims for services by foreign providers must be processed within the timeframes established by Conn. Gen. Stat. §38a-816(15)(B)(i) and (ii).

The Department expects health insurers and other claims paying entities to promptly conclude all disputes and investigations described herein. Specifically, when there is a deficiency in the information needed for processing a claim, the Department expects the insurer, health care center or other claim paying entity:

- For claims filed in paper format:
    - Send prompt written notice to the claimant and health care provider of the alleged deficiencies prior to the expiration of the sixty-day period specified by Conn. Gen. Stat. §38a-816(15)(B)(i). Follow up within thirty days where necessary requested information has not been received. Such claims must be paid within thirty days of receipt of the necessary information.

- For claims filed in electronic format:

- Promptly notify the claimant and health care provider of the alleged deficiencies prior to the expiration of the twenty-day period specified by Conn. Gen. Stat. §38a-816(15)(B)(ii). Follow up within ten days where necessary requested information has not been received. Such claims must be paid within ten days of receipt of the necessary information.

C. <u>Request for Legitimate Dispute Status</u>

Please be advised that claim settlement delays resulting from investigations or inquiries pertaining to disputes other than those identified above will not be considered a legitimate dispute as set forth in CUIPA unless the prior approval of the Commissioner is sought and obtained by the claim paying entity for a specific claim. Any request for legitimate dispute status must including the following: (i) complete description of the claim, (ii) the specific information lacking from the claim submission, and (iii) why the information is necessary for consideration of the claim. The required information, along with a complete copy of the claim file, must be submitted to the Department's Consumer Affairs Division for consideration. The Department will track these requests and consider supplementing the legitimate dispute listing above.

Any claim settlement delay not deemed by the Department to be a legitimate dispute in accordance with this Bulletin, will be treated by the Department as a per se violation of CUIPA and subject to the applicable penalties.

Please contact the Insurance Department Consumer Affairs Division at insurance@ct.gov with any questions.

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Insurance Commissioner